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ABSTRACT

The National Institute of Mental Health (NIMH) estimates that for every high school of 2,000 or more students in the United States, there is at least one successful suicide and thirty to fifty attempts each year. This report offers one state's examination of suicide and presents some effective responses to this problem. Discussed are those students most at risk, legal issues, guidelines for developing policies and procedures, and some general prevention strategies. Ten appendices include a sample suicide intervention model, typical distress signals, a profile of youth at high risk for depression, symptoms of depression, a lethality assessment, guidelines for responding to suicidal ideation, resources on the topic, and examples of crisis management training. Suicide prevention is falling more upon the schools and having an effective suicide prevention program in a school depends on the participation of students and parents in all aspects of the program. Schools should also enlist community support. Outside agencies can serve as consultants, referral sources, and trainers of staff and students. (RJM)

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AZ-TAS
Themes & Issues

A Series of Topical Papers on Special Education

Youth Suicide: A Special Problem in Need of Preventive Planning

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Arizona Department of Education

Special Education

Arizona Department of Education
C. Diane Bishop, State Superintendent of Public Instruction
February 1992

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A Teenager's Point of View

The following was a 16 year-old Indiana boy's impression of youth suicide:

> *"For each suicide or attempted one, there are many that go unseen, hidden beneath long-sleeved shirts and well-developed excuses. This is what has happened to me recently:*
>
> *- Five days ago, a close friend revealed to me the loaded gun he keeps hidden next to his bed.*
>
> *- Four weeks ago, I found my best friend's sister at home with both wrists slit. We managed the best cover-up yet. Her mother didn't even suspect anything.*
>
> *- The threats, ideas and discussions are too numerous to mention here. The best way to find out how common the thought of self-destruction is would be to ask the teenagers. They know, they can tell you and they need to talk, even if it means revealing their secrets."*

He went on to write the following poem:

16 Year Old Despair

Death all around me
Thundering in my ears
Doesn't anyone understand?
We have cause to fear.

Useless it is to strive
Useless it is to survive
When all we hear
Is that death is near

If the best is now?
Why meet the future?

Jeremy M., age 16

SOURCE: *Youth Suicide: A School Approach for the Prevention of Youth Suicide in Indiana.* Indiana State Board of Health, 1988.

Introduction

The National Institute of Mental Health (NIMH) estimates for every high school of 2,000 or more students in the United States, there is at least one successful suicide and 30 to 50 attempts each year. The statistics and the studies which fill volumes, all tell us the same thing: suicide among the young is a problem which has been steadily growing and shows no signs of going away.

The most extensive study to date on the mental health of teenagers found that many more adolescents than previously suspected are subject to mental disorders. Some of these can be so severe as to lead to attempted suicide. A 1990 study in the Archives of General Psychiatry, found 17.8 percent of the 5,600 public and private high school students studied claimed that they had at some time suffered from mental disorders such as major depression, panic disorder, anorexia nervosa, bulimia, and generalized anxiety disorder. Researchers in the study noted that the rate of mental disorders among adolescents is probably even higher since dropouts, institutionalized teenagers or those in residential out-of-home care were not included in the study. Moreover, the study concludes, potentially life-threatening conditions often go undiagnosed and untreated. In addition, the study found that 60 percent of those identified as having an emotional disorder or handicap had never received any kind of treatment or therapy. Severe depression is a common factor in most suicides and one in six people who suffers from severe depression will eventually die by suicide.

It was no surprise to those working in schools that researchers from NIMH found phobias, major depression, and alcohol and other drug dependency of youth becoming a problem earlier in student's lives than previously believed. That trend should reinforce educators' resolve that prevention plans must be instituted at both elementary and secondary schools.

Experts believe children and adolescents do not typically outgrow mental and emotional disorders. The emphasis in intervention strategies, therefore, is shifting from reacting to crises to planning for early identification and prevention of problems to avoid years of needless suffering.

In response to increased public concern, suicide prevention has been added to the ever-lengthening list of education's responsibilities, often mandated by legislative action or district policy. Most school-based suicide prevention programs provide primarily for detection of signs of depression and/or suicidal intent and referral to mental health professionals for diagnosis.

Most programs also describe procedures to follow in the aftermath of a suicide. Some provide for additional interventions in the school setting for children at risk for suicidal behavior, including crisis intervention; counseling; discussion groups; modifications in courses of study, schedules, and curriculum; and referral to special education for assessment.

Suicide prevention, once the sole province of mental health facilities and practitioners, has become a responsibility of the schools. Although not all suicidal students will become the responsibility of special education programs, special education personnel and services

are important to the effectiveness of a school suicide prevention program. For exceptional students, an appropriate special education program may be an important contribution to suicide prevention.

An Arizona Perspective

In Arizona (ranked second in the United States for rate of adolescent suicide in a 1990 Governor's report), suicide is the second leading cause of death for people aged 13 - 19. Another alarming Arizona trend is the continuing increase of suicide and attempts by youngsters under 13. The facts present a tremendous challenge for our schools and for anyone who deals with children and adolescents. Educators are scrambling to define the roles of the school, the teacher, the school counselor, and nurse in suicide prevention.

Arizona Suicide Facts

- Nearly three times more people of all ages killed themselves in Arizona in 1987 (687 suicides) than 1970 (266).
- The suicide rate among children 5 - 14 is today at least 30 percent greater than the 1986-87 rate of one per 100,000 children.
- One in 16 boys and one in 22 girls who died in 1987 did so by his or her own hand.
- The 1987 suicide rate among males was 3.6 times greater than the corresponding rate among females. The 533 male suicides in 1987 equaled the total number of suicide deaths for both genders in 1984.

SOURCE: *Arizona's Children...A Special Report*, Governor's Office for Children, May-June-July 1990

Special Education Students at Risk

Many children and youth with special needs in Arizona may be at risk for suicidal behavior, but not all suicidal children qualify for special education services. If a school district already has a prevention or student assistance program, special education may only have the responsibility of plugging into the existing plan. In many districts however, it may fall on special education to plan and implement suicide prevention programs in the schools.

Exceptional children, both handicapped and gifted, are often vulnerable to emotional trauma, which may lead to stress, feelings of low self-esteem, and ultimately to suicidal behavior. Studies of children who have committed suicide have often revealed disproportionate numbers of exceptional children among those completing suicide. (Jan-Tausch, 1964; Peck, 1985; Shaffer, 1974)

Students with Learning Disabilities

Several authorities have observed that children with learning problems may be at high risk for both depression and suicidal behavior. Researchers have noted relationships between depression and cognitive deficits (Brumback, Staton, & Wilson, 1980) and between suicidal behavior and diminished problem-solving abilities (Levenson & Neuringer, 1971).

In a pilot study of all children under 15 who had committed suicide in Los Angeles County during a three-year period, it was found that 50 percent had been diagnosed as having learning disabilities (cited in Peck, 1985). Pfeffer (1986) has cited depression and suicidal behavior as special problems of learning disabled children who are excessively stressed by the demands of school. According to Pfeffer (1981), the most important issue seems to be the child's level of concern about academic achievement rather than actual school performance. Low self-esteem is a major contributing factor.

Students Who Are Gifted

Gifted children are not immune to problems of stress, depression and suicide. The director for gifted and talented on the National Education Association's Caucus for Educators of Exceptional Children has described the suicide rate of gifted students as "among the highest" (Innis, cited in "Educating the Gifted" p.5). Other authorities have also noted suicidal behavior in gifted and talented youth (Delisle, 1986; Leroux, 1986; Willings & Arseneault, 1986).

Students With Severe Emotional or Behavioral Problems

Severe behavioral disorders are by far the most prevalent handicapping conditions associated with suicidal behavior. Many studies have confirmed the link between suicidal behavior and emotional instability (Cosand, Bourque, & Kraus, 1982; Garfinkel & Golumbek, 1974; Jan Tausch, 1964; Pfeffer, 1986; Shaffer, 1974; Toolan, 1962).

According to Garfinkel (cited in Strother, 1986), young people rarely kill themselves without having some kind of psychiatric disorder. In a report to the U.S. Senate Subcommittee on Juvenile Justice, researchers from NIMH estimated that 60 percent of American teenagers who kill themselves are suffering from some mental disorder. (Blumenthal, 1985) The researchers further noted that many troubled youth fail to seek professional help because they do not want to be considered mentally ill.

Suicide Clusters and the Exceptional Student

Some special education students may also be more at risk of participating in the "suicide cluster" phenomenon where one suicide appears to trigger additional suicides in a group, such as the school or community. All special education students, regardless of eligibility category, may be vulnerable to suicide clusters for different reasons. Severely emotionally handicapped students as mentioned above, frequently display emotional instability, depression, and low self-esteem, so might perceive a classmate's suicide as a glorified way to escape problems and make others forget all their previous negative behaviors. These students very typically see revenge as a motive for some actions, or even see negative attention as preferable to no attention at all, and may imitate the suicide of others because of the drama and publicity that suicide created.

Other special education students with low intellectual capacities, for example, may be so concrete in their thinking that they do not understand the abstractness of many of our prevention strategies in the schools. They may be highly imitative even of destructive behaviors not perceiving the realities of dying. Any preventive strategy planning, therefore, such as a prevention curriculum, classroom role playing, special speaker, or counseling groups must consider the wide differences among exceptional students, ranging from gifted to severely mentally handicapped.

Special Education's Responsibility

Special education and related services personnel should participate in the development and implementation of school or district plans for suicide prevention or student assistance. While not all suicidal children will be placed in special education, special educators -- who are not strangers to the problem of suicidal behavior -- can be valuable resources to the school district.

Special educators have been trained to observe children, assist in the diagnostic process, work closely with parents, plan appropriate interventions, and evaluate outcomes. They usually have established working relationships with mental health professionals and representatives from other community agencies who are vital to the success of a suicide prevention program. They also are attuned to the need for a positive school environment, which is prerequisite to effective suicide prevention. In some communities, the special educator may be the only trained professional available to work with a suicidal child.

The knowledge and abilities of special educators have not gone unnoticed by experts in the field of suicide prevention. Berkovitz (1985) has listed special education as an important resource for prevention of suicidal behavior, and a report from the U.S. Department of Health and Human Services stated the following:

> *"Many programs that are not directly aimed at suicide prevention, such as special education programs or family counseling services for adolescents with behavioral problems, may have an effect on the suicide rate. In any particular location, these indirect programs may be more important than programs designed to prevent suicide."*
> (Centers for Disease Control, 1986)

Legal Issues

Although it is a general principle of law that one who does not cause another's peril is under no legal duty to rescue the other person, when some special relationship exists between the parties, social policy may justify the imposition of a duty to assist or rescue one in peril, which gives rise to legal liability. A special relationship exists between a special educator and the special education student, as well as between a school psychologist or counselor and a special education student.

Some recent court opinions have indicated that this relationship may be sufficient to impose legal liability for failure to respond appropriately to the suicidal student.

School personnel may not be diagnostic clinicians or clinical therapists, but they are experts in teaching and guiding. The courts, therefore, hold schools and school personnel accountable for an ethical, moral, humanitarian and legal responsibility when the health, safety and welfare of young people are threatened. The schools may not be held responsible for the causes of a potential suicide, but may be held accountable for doing all they can to prevent it from being carried out.

Guidelines for Developing Policies and Procedures

Youth suicide will not decrease without community prevention and intervention efforts. School districts are positioned to provide leadership for prevention programs. The following guidelines for creating policies and procedures to address suicide are offered to school districts in the hope that they will lead to the development of operational procedures which can be followed by school district personnel.

In developing policies and procedures, several important principles should be remembered.

1. **Parent contact.** Parents should be contacted whenever their child is presenting a danger to him or herself or to others.

2. **Screening.** School personnel should be available and accessible to students needing to communicate personal concerns. School personnel should be trained to screen for suicidal ideation. Substance abuse, psychiatric illness, chronic running away and physical or sexual abuse can place children at-risk for suicide.

3. **Home-school-community communication system.** A contact person at the school should set up a home-school-community system to monitor the activities of students identified as potentially suicidal.

4. **Referral.** Students who have serious problems or make suicidal threats or attempts should be referred to psychiatrists, psychologists or counselors who are trained and licensed to treat suicidal youth.

While it is not the responsibility of either the special education staff or other school officials to provide treatment, it is the responsibility of schools to protect children when they are at school. The procedures described below may help to prevent suicides and to protect schools from liability if a suicide does occur.

Steps to Follow

To establish policies and procedures that prepare school districts for crises such as suicide there are three general steps to follow:

Step 1: Community Involvement

Suicide is a social problem. Consequently, it requires cooperative social solutions. For schools to effectively intervene with suicidal students, a concerted effort must be organized among teachers and others in the caring professions, both inside and outside the school system.

The community group should develop suicide prevention policies and procedures. Involvement of a broad cross section of the community will increase commitment and create a network of professionals seeking a solution to the suicide problem.

Before writing policies and procedures, the school district should gather information about available community resources, including the names and addresses of contacts to whom schools can refer students and families in times of crisis. The referral network might include mental health centers, private hospitals, psychiatrists or psychologists in private practice, churches, and local law enforcement agencies.

Having many agencies involved in the suicide-prevention program will expedite training of suicide-prevention staff and will guarantee the availability of a range of support services in the event of a suicide threat, attempt or completion. Various agencies working together should be better able to identify and solve community problems that may increase the risk of youth suicide than any one agency working alone.

The school district should develop a network among the schools and other public agencies to exchange information about suicidal students who need support services. The challenge in establishing such a network will be to exchange significant information while protecting the student's right to confidentiality.

Included in the appendix of this document are materials and other resources that have been developed to deal with the problem of youth suicide.

Step 2: Develop Written Policies

The school district should write suicide-prevention policy based on an analysis of community needs and careful study of the role of the schools in the community. The policy should be evaluated on a regular basis to ensure continuing responsiveness to community need.

The following is an example of a possible board policy:

> *The board has committed itself to providing the leadership within the community to act in concert with other organizations and agencies to develop a community-wide approach to dealing with the problems of youth stress,depression and suicide. The board feels it is imperative that cooperative planning and action*

be taken among all agencies and persons involved with youth in identifying, preventing and intervening in stress, depression and suicide among our youth.

The board's concern is reflected in the district's stated goal 'to increase community awareness of the needs of at-risk youth and to improve the district's ability to educate and assist those students.' The board supports the cooperative community-wide development of specific administrative procedures and training strategies to assist youth in crisis and their families.

Step 3: Develop Written Procedures

Policy statements should be refined into specific procedural guidelines that prescribe specific action to be taken in the event of a suicide threat, attempt, or completion. The procedures outlined below are applicable to four kinds of situations that may arise:

1. Suspected suicidal ideation
2. Suicide threat
3. Suicide attempt
4. Suicide completion

The sequence of actions described in the four situations below should be adapted to the existing circumstances and/or procedures in individual school districts:

1. Suspected Suicidal Ideation

Staff must be trained to recognize a suicidal ideation, understand what their responsibilities are when an ideation occurs, and know what action to take.

2. Suicide Threat

In the event of a suicide threat the following actions should be taken:

a. Have an appropriately trained staff member such as a school psychologist or counselor trained in suicide assessment evaluate the risk and provide immediate crisis intervention services to the student. Threats of suicide should never be taken lightly.

b. Remove the student from any area containing any dangerous substances and/or implements, and remove any dangerous substances or implements from the student.

c. Do not leave the student alone until either it is determined that the student is no longer in danger, or until that student has been referred to appropriate treatment.

d. Notify the parents.

e. Have the contact person at the school set up a home-school-community communication system and notify other school personnel about the need to monitor the student.

3. Suicide Attempt

In the event of a suicide attempt (defined as any behavior or gesture that indicates an intent to take one's life) the following actions should be taken:

a. Treat it as a medical emergency. Call Emergency Medical Services, if necessary.

b. Have a staff member stay with the student at all times.

c. Remove all dangerous substances and/or implements from the student and from the area.

d. Notify the parents immediately.

e. Have an appropriately trained staff member assess the situation and provide crisis intervention services.

f. Involve psychological or consultation services through the community referral system.

g. Have the contact person set up a home-community communication system and notify other school personnel (school administrators, counselors, nurses, and teachers) about the need to monitor the student. If appropriate, the school could develop and implement an Individual Assistance Plan with the student, school, family, and other involved agencies.

h. Urge parents to seek immediate treatment for the student. The district should document any such encouragement and the parents' response. If the parents do not respond, the student should be referred to the Department of Economic Security, Child Protective Services.

4. Suicide Completion

If a suicide is completed, the following actions also appropriate to a suicide attempt should be taken:

a. Treat it as a medical emergency and call Emergency Medical Services.

b. Have a staff member stay with the student.

c. Notify the parents immediately.

d. Notify staff members.

In addition, the following actions should be taken:

a. A school crisis team meeting should be called. The crisis team should be organized prior to a crisis and should include school and/or district

administrative, counseling and psychological services staff, teachers, and nurses. Professionals from outside the schools also may be included, such as psychiatrists or psychologists, community mental health professionals or emergency response mental health personnel. After a suicide completion, the crisis team should identify students who are at the highest risk for suicide, including students who were close friends of the victim, students who seem particularly troubled by the suicide, students who have themselves made suicide attempts or other high-risk students with poor coping skills.

b. The superintendent's office should be notified about the suicide. The superintendent should notify all principals, counselors, and other appropriate personnel.

c. All building personnel should be notified about the suicide and the post-suicide plan should be implemented.

d. Factual information about the suicide should be communicated to school staff and to the students. Rumors should be dispelled. General announcements of the suicide are not recommended, unless accompanied by counseling and educational support in all classes.

e. Parents of any students expressing strong emotional reactions or suicidal ideation should be notified. Those parents should be urged to seek treatment for their children.

f. Members of the crisis team should make presentations to each class in which the student was enrolled and discuss the facts of the student's suicide and the futility of suicide. All students who want to discuss the subject further should be urged to see the school counselor or other especially trained staff. If any students are experiencing strong emotional reactions, their parents should be notified and the students should be referred for treatment.

g. All teachers should set aside time for students to discuss their reactions to the tragedy, and students who seem very upset should be referred to the counseling team.

h. Counseling services should be made available to those students who have been identified as at-risk for the length of time that the crisis team deems necessary. Referral for treatment to community agencies or hospitals should be made, if appropriate.

i. School inservice sessions and counseling time should be made available to all school personnel to help them deal with their own reactions to the suicide.

j. Neither the student nor the suicidal act should be glorified or memorialized in any way.

While the procedure should clearly state that the special education assessment process should not be used in lieu of immediate parental notification or as the initial resource in assessing risk when more immediate steps are obviously indicated, provisions should be made for the referral of a suicidal student for special education assessment.

The teaming process used for determining eligibility for the seriously emotional handicapped area can be helpful in determining which staff and resources are available to intervene with a student, who, while not determined to be immediately at risk, may evidence behaviors that suggest a high-risk profile for suicide. The procedures also should suggest that during the assessment process, interventions should be implemented that diminish suicidal risk, for example, parental contact or involvement, use of school staff who offer a safe and supportive environment, and disciplinary approaches that do not increase the student's sense of failure. It is extremely important to secure the cooperation of family, friends, school personnel, neighbors, and others who will assist in providing support and supervision for the student. Parents must be warned that a suicidal student should not be left alone.

Another important suggestion is (and should be standard practice for any special education program) to secure written parent permission for the school to communicate directly with treatment providers. The treatment plan and the school intervention plan must work closely together, not at cross purposes.

General Prevention Strategies

Ninety-five percent of youth suicides can be prevented. Only five percent of the adolescents who attempt suicide display psychotic symptoms such as disorientation, hallucinations or thought disturbances and are intent upon self-destruction. Further, poor school adjustment -- including poor grades, truancy and discipline problems at home or school -- may contribute to a student's level of risk. The school may want to consider implementing preventive measures with school personnel, students and parents as suggested below.

School Personnel

School staff often feel anxious when confronted with a teenager who says he or she is suicidal. That anxiety often is the result of inadequate training in dealing with self-destructive behavior. For a school to have an effective intervention program, however, staff members must become involved with troubled youths.

Certainly suicidal young people should be referred for professional help, but equally important is the support they receive in relationships with other caring people, be they teachers, parents or friends. Early intervention by any caring person can be a lifeline to be grasped while other steps are taken. Training school staff to recognize potentially self-destructive students carries little risk and could save lives.

Training and utilization of school personnel should include the following:

1. In-service training on stress in children and adolescents and methods of reducing stress in a school environment.

2. In-service training on recognizing the signs of substance abuse, sexual abuse, physical abuse, depression, and other handicapping disorders that could make a student suicidal.

   Early identification should be emphasized. Referrals can be made to the crisis team with follow-up memoranda of all referrals. Educators must become better observers of students' behaviors, more supportive and less prone to labeling of deviant behavior when it occurs in their classrooms.

3. Delegating the leadership for implementing a youth suicide prevention program to a crisis intervention team selected from, willing and qualified faculty.

   The team may consist of administrators, guidance counselors, school psychologists, nurses, social workers, or qualified teachers. A supportive staff member like a secretary may also be very effective on a crisis team.

   a. Selecting one member from the team (preferably by the team) to be the team's formal leader.

   b. Educating the team members about crisis intervention techniques, including the philosophy that crisis intervention is not psychotherapy, but is an easy way to restore students to their former emotional and behavioral states.

   c. Emphasizing the importance of follow-up of referrals. A large number of students who may be at-risk never receive help, although help is desperately needed and often desired. Schools should adopt policy concerning students who refuse help or are unable to receive needed help because of finances or lack of parents' cooperation.

4. Developing written policies and procedures for dealing with suicidal or depressed youths. Written policy or procedures on how to intervene with youths suspected of abusing drugs is imperative. The policy can include the following:

   - When and how to refer to the crisis team
   - When and how to inform parents
   - When and how to inform administrators
   - When and how to counsel the youth
   - How to obtain an assessment of the potential and capability of causing death (lethality)
   - When and how to refer the youth to a mental health center

Students

Perhaps the most controversial part of a school-based suicide prevention program is teaching prevention to students. Yet students may be the first to recognize that a friend or acquaintance may be suicidal. Many times a potential suicide will state his or her intentions to friends. If students know the warning signs of self-destruction and know where to refer a friend, they can be a great resource in the suicide prevention effort. Other steps the school may want to consider are as follows:

1. Developing a health curriculum for every student with the following suggested topics:

    a. Positive self-esteem with an "I'm okay, you're okay" focus.

    b. Effective interpersonal skills with peers and adults including beginning, maintaining, and terminating relationships. (Learning social skills for dating and school activities can be beneficial.)

    c. A positive attitude toward loss, failure, and grief. (Learning how to fail is as important as learning how to succeed.)

    d. Life skills, including decision-making, values clarification and problem-solving.

    e. Stress management skills.

    f. Substance abuse information and the effects of drugs on the body.

    g. Depending on the community and school governing board stance, a component related to sexual topics and/or other health topics such as AIDS.

2. Developing a peer support program (sometimes called peer counseling) with components such as the following:

    a. Youth-staffed hotline.

    b. Problem-solving with a peer. (Note: The National Youth Suicide Conference emphasized avoiding the phrase "peer counseling" as it can be misleading to students. It is recommended that peer counseling be called peer "support" and the focus be on support.)

    c. Self-help groups for maltreated teenagers and for other students who would benefit from a group experience, such as those whose parents are divorcing or those who have suffered the death of a parent.

3. Developing a pamphlet for youth on guidelines for recognizing maltreatment and ways to help maltreated peers.

4. Developing a pamphlet for recognizing cues to suicide in their classmates.

5. Preparing school newspaper articles.

6. Presenting school plays or showing films on the problem of youth suicide and following up with resources for help.

Parents

Parents are often aware that their children, or their children's friends, are experiencing difficulties, but are hesitant to label such difficulties as serious or to consider these children at risk for suicidal behavior.

Schools can assist parents to become better observers and to identify times to seek help for their children by holding workshops to educate parents about indicators of substance abuse, depression, and suicide. Workshops can focus on ways to prevent youth suicide and describe the relationships among substance abuse, depression and suicide.

Parents should be educated on how to have more effective communication with their children. Many parents, devastated by the suicide of a son or a daughter, recall certain behaviors that may have indicated a potential for the suicide. Others feel that there were no warning signs. No parent can fully know what to expect, but there are things a parent can know and do that might prove helpful in saving a child.

Parents of young people should observe these guidelines:

1. Be aware that extreme behavior patterns are not necessarily normal or characteristic of all adolescents. Such behavior may be a sign that a child is disturbed.

2. Don't assume that bouts of depression by a child are just a stage that will pass with time. For teens who have limited coping skills, mild depression can turn to deeper depression accompanied by thoughts of suicide or other forms of self-destructive behavior.

3. Be aware of a son's or daughter's involvement with school, peers and the community.

4. Be empathetic when problems such as a failed romance occur. For some adolescents, such perceived failures can create an emotional crisis.

5. Recognize that major changes in the family structure can be very difficult for an adolescent. Such trying situations may include separation and divorce, living in a step-family or a change in residence or school.

6. When major changes in a child's personality are observed, seek an opinion from a qualified mental health professional.

7. Work with school teachers and counselors when there is a problem.

Conclusion

Having an effective suicide prevention program in a school depends on the participation of students and parents in all aspects of the program. Excellent parental and student resources can be found in every school.

Involving parents and students in the development and implementation of a prevention program and delegating the responsibility for implementing the program to a trained crisis team is a good first step toward preventing youth suicide.

The next step is to enlist community support. Identify community support services for youths. If there are none, start some. Schools also must maintain a collaborative relationship with community agencies involved in suicide prevention, education and intervention. Outside agencies can serve as consultants, referral sources and trainers of staff and students. By maintaining a collaborative relationship, follow-up of referrals can be better realized, particularly if there is a mental health liaison person at each school who can serve as the leader of a crisis team.

Many physicians and counselors in private practice may be willing to help with the problem of youth suicide and should be invited to do so. A list of community resources dealing with the problems of adolescence should be developed and distributed to all youths and their families.

Although not all suicidal students will become the responsibility of the special education program, special education personnel and services are important to the effectiveness of a school suicide prevention program. For exceptional students, an appropriate special education program may be an important contribution to suicide prevention.

A Friend Says Goodbye

After the death of a student at Irondale High School in Moundsview, Minn., a "survivors group" was offered to students who needed support to work through their feelings. One of the tasks suggested to group participants was to write a farewell letter to their friend. Here is what one student wrote:

"How's Heaven? I hope you have found what you were looking for. I don't really know what to say to you right now, because I guess I never could understand why you had to die.

Of all the people in the world I would have never thought you would not want to live. Why Steve? What was so bad down here that you couldn't handle?

You hurt a lot of people with your decision. Your mom and dad and Mike and Paul are crushed but like you are very strong people. Kris seems to be getting better and all us guys have pulled together and are getting through the tough stuff together.

I know you're dead and not coming back so I guess I will close discussion on a good note. While you were here you were a treat to almost everyone who came into contact with you. All the guys, including myself, love you very much. Take care of yourself and I'll see you in about 80 years."

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Appendix A

Sample Suicide Intervention Model (Edgewood High School)

Edgewood High School Model for Suicide Intervention

Developed by Willard Cazzell, Assistant Principal, Edgewood High School

Edgewood High School is located in Ellettsville, Indiana. The school is the smallest of three high schools located in Monroe County. There are approximately 800 students enrolled in grades nine through twelve. Students come from a suburban rural setting.

This model was developed to try to break the cycle of multiple suicide after two freshman students had committed suicide within a three-week period of time.

PLANNING

After the first suicide contacts were made to various professionals to get an idea as to how to handle the situation on the school level. What should we be doing, or not be doing, as a school in this situation? We recognized that after one suicide there could be others.

Requests were made to dismiss school so that all students could attend the funeral. We denied the request because the situation was becoming glamorized. Another request was made to hold the funeral in the school gym. We also denied that request on the basis that not all students would want to attend the funeral and should not be put in that position by the school. We granted individual telephone requests from parent to dismiss their children to go to the funeral.

We held a staff meeting to alert teachers to the signals that they might be getting from student that might indicate further problems. We also agreed that we would discuss suicide if the students wanted to talk about it individually, or in class.

After the second suicide and a third attempt, we felt that a concerted effort was needed to try to break the cycle that had begun. Since nearly all teenagers in the community come to school we felt that they could be reached through a school program most effectively.

A planning meeting was scheduled and attended by representatives from the mental health center, family services, the local ministerial association, school counselors and administrators from both the high school and middle school.

While this meeting was in progress we began to get calls and visits from newspapers and television stations. One of our first acts was to establish a policy on dealing with media coverage. The following program is outlined in more detail and was what finally emerged as our plan of action.

The program involves mental health professionals, family counselors, community minister, parents, school counselors, teachers, administrators, and students.

LARGE GROUP PRESENTATIONS

An assembly program was presented to freshmen and sophomores lasting approximately forty minutes. In our situation the assistant principal delivered a short memorial to those who had committed suicide and asked students to consider what their last memories of the suicide victims would be. We pointed out that many of the students were having a difficult time coping with their grief. We discussed the typical feelings that some of them might be having about the situation.

The parent of the first victim, a girl, volunteered to come to speak to the students about what it was like to come home and find your daughter dead. She also spoke about all of the ugly rumors that started about her daughter shortly after her burial. She related how it is at home for the rest of the family.

A second assembly was held for juniors and seniors at which time a very similar format was used. We felt that two assemblies were better than one. Some of the students in the younger group were more involved with the victims than most of the older students. Also, small groups of the younger students could begin meeting while the second large group presentation was in progress. This allowed us to use the limited resources of the family service and mental staffs more efficiently.

SMALL GROUP PRESENTATIONS

Following the large group presentation students were broken into groups of approximately twenty to twenty-five. A mental health professional, or family service counselor along with a teacher presided over these groups.

In the groups students were encouraged to express their feelings about what had happened and to ask questions about their feelings. They were also given a blank index card to write anything they wanted to write about the situation, or to ask a question privately. They were also encourage to request a conference to talk with anyone they would like if they were having difficulty in copies with the deaths of their friends. They could request a minister, school counselor mental health or family service counselor, teacher, parent or friend. The cards were presented to the mental health or family service representative who stood at the door to collect them. Students were told that these would be the only people to see their comments or requests. The responses were tallied and categorized by the Family Service Agency and were use as a basis for the next phase of the program which was individual counseling.

INDIVIDUAL COUNSELING

Four hundred students responded in some manner on the cards. Some made comments about the program, their own feelings, asked questions, thirty-two requested individual counseling, eight made comments that alerted mental health people to think they needed counseling. Four cards contained negative comments about the program.

Family Services made staff available at the high school for two weeks to counsel the students who had requested help and those that they identified as possibly wanting help. Some students and parents were referred to the centers for further counseling after these initial sessions at school. While the mental health center was not involved in counseling at the school site during the later stages they handled calls and those who came into their center during this time.

PARENT MEETING

Parents were encouraged through the media to come to a presentation at the high school to hear mental health people speak on things they should be recognizing as possible signs of depression and potential suicide in their children. School personnel were not involved in this meeting other than providing a place to meet and informal discussion with various parents after the formal meeting. Approximately six hundred parents attended the meeting.

PEER SUPPORT GROUPS

We have implemented a limited peer counseling program to have an ongoing program of student to student contact to meet their needs. This program is not what it could be. More effort through more training for the students who participate as peer counselors is needed.

PARENT SUPPORT GROUP

A parent support group was organized to talk about common problems they have in raising their teens, and ways that they have successfully solved some of the problems. This group was revitalized in the spring of 1987 as part of the "Generation at Risk Program" and is not sponsored by the school, but is supported by the school in various ways such as provision of a meeting place, help in duplicating materials to be sent to parent, and sending materials home with students.

Original Transcript: 10/18/85 Update: 09/16/86 09/15/87 ---- Willard Cazzell, Assistant Principal, Edgewood High School, Ellettsville, IN 47429, AC 812/876-2277.

Appendix B

Distress Signals

Distress Signals for Suicide

- Acting out, aggressive, hostile behavior, truancy, cutting classes
- Abrupt changes in personality*
- Sudden mood swings (sudden positive behavior following a period of especially serious depression)*
- Giving away prized or personal possessions*
- Obsession with death, a death wish, death themes in drawings and poetry*
- Discussion of suicide or making a suicidal plan*
- Accident prone
- Alcohol and drug abuse
- Passive behavior
- Changes in eating habits
- Changes in sleeping habits
- Fear of separation
- Impulsiveness
- Slackening interest in school work and decline in grades
- Inability to concentrate
- Loss or lack of friends
- Loss of an important person or thing in the child's life*
- Hopelessness, helplessness, and anger at self and the world*
- Writing a lot of letters to friends*
- Previous attempt!!*
- Scratching, self-mutilation, or other self-destructive acts*

* *These cues are indicative of a high potential for suicide, particularly if depression and/or substance abuse is present.*

SOURCE: *A School Approach for the Prevention of Youth Suicide in Indiana*; Indiana State Board of Health, (1985, Revised 1988).

Appendix C

Youth At High Risk for Depression

Youth at High Risk for Depression

- Those who suffered a recent, major loss, like breaking-up with a girlfriend or boyfriend, failure in a class or change in body part or function
- Loners
- Those who lack social skills
- Over-achievers and under-achievers
- Learning-disabled and other special education students
- Those under pressure
- New students
- Adopted children or step-children with inadequate family bonding

It is important to note that the above characteristics are often combined with one or more of the following:

- Poor parent/child relationships
- Absent parents
- Divorced or divorcing parents
- Internal family conflict, either between parents or siblings
- Conflict in blended families
- Financial problems, breadwinner in family unemployed
- Cultural changes
- Member of minority
- Personal pathologies
  - obsessions
  - fantasies
  - unrealistic fears
  - little impulse control
- Family pathology
  - one or both alcoholic parents
  - depressed parents
  - abusive parents
  - mentally ill parent or parents
  - suicidal parent

(Adapted from Kinzey, Dorothy, 1984) SOURCE: "A School Approach for the Prevention of Youth Suicide In Indiana." *Indiana State Board of Health,* (1985, Revised 1988)

Appendix D

Symptoms of Depression

Symptoms of Depression in Youth

- Feelings of emptiness in life, loss of interest in usual activities
- Risk-taking behavior (driving fast, recklessly)
- Rebellious refusal to work in class or cooperate in general
- Sadness (in children under six years of age, may be inferred from a persistently sad facial expression)
- Anger and rage (typically expressed by verbal sarcasm and attack in angry outbursts)
- Inability to concentrate or make decisions
- Sensitivity with inclination to over-react to criticism
- Fluctuations between indifference and apathy on one hand and talkativeness on the other
- Feelings of insufficiency to satisfy ideals
- Poor self-esteem (self-criticism and blame, sense of personal failure)
- Feelings of helplessness and decreased peer support
- Withdrawing from friends, excessive television watching
- Intense ambivalence between dependence and independence
- Restlessness and agitation (inability to relax)
- Mood swings (the quiet youngster becoming hyperactive, the outgoing youngster becoming withdrawn)
- Pessimism about the future
- Death wishes, suicidal ideas, plans,and attempts
- Sleep disturbance (decreased or increased)
- Increased or decreased appetite
- Weight gain or loss (anorexia)
- Somatic problems (headache, stomachache)

NOTE: A distinction must be made between clinical depression and the normal mood swings experienced by adolescents. The distinction is based on the **duration and intensity** of symptoms. If the symptoms last for at least two weeks or if there is impairment in normal functioning, a depressive disorder might be present.

SOURCE: " A School Approach for the Prevention of Youth Suicide in Indiana", Indiana State Board of Health, (1985, Revised 1988)

Appendix E

Lethality Assessment

* Lethality Assessment

<u>These signs, seen even only ONCE, represent a VERY HIGH Lethality</u>

Giving away of personal possessions	YES	NO
Discussion and/or making of suicide plans	YES	NO
Discussion and/or gathering of suicide method	YES	NO
Previous suicide attempts or gestures	YES	NO
Scratching, marking body, other self-destruction	YES	NO
Death themes throughout spoken, written, and art works	YES	NO
Expression of hopelessness, helplessness, and anger at self and the world	YES	NO
Use of dark, heavy, slashing lines, unconnected bodies in art work and doodling	YES	NO
Statements that family and friends would not miss them	YES	NO
Recent loss through death	YES	NO
Recent loss through suicide	YES	NO
Sudden positive behavior change following a period of depression	YES	NO
Anniversary of a significant loss	YES	NO

* The tool on lethality assessment has been reprinted here through the courtesy of the Suicide Prevention Center, Dayton, Ohio. Lethality is defined here to mean the potential and capability of a person to causing death.

Appendix F

Plain Talk About Adolescence

Plain Talk About Adolescence

In the United States, adults generally view adolescence as a period of friction, change, and problems. Many teenagers would agree. For most boys and girls, adolescence starts between the ages of 10 & 14 and continues to between 19 & 21.

For the teenager, it is a time of concern about acne, weight problems, menstruation, late development, early development, sexual arousal, school pressures, boredom, parental hassles, peer pressures, and money problems.

It is a time of confused feelings, particularly in relationships with parents. Teenagers light for independence yet fear too much freedom; they resent over-protection but need and want parental attention. .

For parents, it is a challenge to keep a balanced perspective on their teenager's emotional roller coaster ride. As their children bounce back and forth between childhood and adulthood, alternating irresponsibility with responsibility, blatantly testing parental authority one moment and depending on it the next, parents often do not know what to expect. They must maintain needed discipline, yet they understand their teenager's growing need for independent action, even for rebellion.

It's easy to understand why many parents and adolescents find this such a difficult period to "survive". But, once it is over, even the most rebellious child often becomes appreciative, affectionate, and devoted. With maturity comes the realization that much of their parents' behavior, once so irritating, was motivated by feelings of love for them. Also, having children of their own brings understanding of the pressures their parents faced.

Parents should also be aware of their own imperfections. At times, lack of knowledge, poor advice, community pressures, or their own stresses can cause them to overreact to teenage behaviors. To avoid making the same mistakes as their parent or to make up for what they missed in their childhood, parents sometimes make mistakes themselves.

Adolescence is a trying period, but it is also an exciting one. If parents and teenagers keep tuned into each other, this period may seem less trying and more fun for everyone.

How Parents Can Help Keep Communications Open*

When asked about their problems with parents, teenagers most often cite "not being listened to". Really listening is not always easy. Nor is communicating. Some of the following suggestions may help.

Give your undivided attention when your teenager wants to talk to you. Don't read, watch TV, fall asleep, or make yourself busy with other tasks.

Try to listen calmly, even though there may be a difference of opinion. Concentrate on hearing and understanding your teenager's point of view. Don't start preaching when a give-and-take discussion is wanted.

Develop a courteous tone of voice in communication. Respect brings respect-even in the way we speak. If we talk to our offspring as we talk to other people, our own youngsters might be more likely to seek us out as confidants. Gruffness or abruptness can arouse hostility, whereas a pleasant tone of voice can pay great dividends in improved relationships.

Avoid making judgments. Anyone avoids confiding in someone who is critical of his or her behavior. It is not necessary to approve all of your teenager's behavior, but it is important to understand the feelings involved. Putting yourself in another's place is not easy, particularly as attitudes, pressures, and choices change. It is a challenge for a parent to be firm about important values while being flexible enough to bend with changing times.

Keep the door open on any subject. Too often teenagers avoid discussing things that may make their parents feel uncomfortable. Belittling humiliating, and laughing at youngsters can cause deep wounds and short circuit the lines of communicating. Teenagers often pay a very high price for not having the right information about many subjects, including sex.

Permit expression of ideas and feelings. Many young people have their own ideas about morality, marriage, work, education, time, money, and whatever else is a part of our way of life. Just because their views and philosophies are different from yours does not mean that they feel certain about them. Often young people "test" their ideas in conversation. To communicate, you must be willing to listen first and acknowledge their opinions, even if you are alarmed by them. Then give your viewpoints as plainly and honestly as you can, recognizing that love and mutual respect can exist, even when points of view are different.

Encourage positive self-worth. Help your youngster build confidence by encouraging (but not forcing) participation in sports, music, art, dance, or any other hobby or interest.

Be aware of how you treat other children in the family. Do you show favoritism? This could make a child feel rejected, unloved, and jealous. Try to be fair and consistent. It will pay off.

Make an effort to say nice things. Too often parents tend to focus on poor performance and behavior. Every human being needs acceptance and appreciation.

Hold family conferences. Most teenagers feel they have little or no voice in family affairs. Family gatherings offer an excellent opportunity for children to participate in decisionmaking and to work things out together.

HOW TEENAGERS CAN HELP

What responsibilities does a teenager have in trying to bridge the generation gap? The following code of communication was formulated with the assistance of both young people and adults;

"*The first barrier to communication which I must cast aside is the attitude of ignoring anybody over 30 years old. If I expect my parents to tune in to me, then I must be willing to talk to them.*"

"*Our generation wants understanding from our elders. In turn it is only fair that we try to understand them-they have needs and feeling and reasons for their decisions.*"

"*I will listen to my parents with an open mind and look at the situation from their point of view. That's the way I would expect them to treat me.*"

"*I will share more of my feelings with my parents. They may have experiences some of the same problems. I need to give them a chance to help me.*"

"*I want my parents to express trust and confidence in me, to grant me more freedom and responsibility as I mature. It is necessary, then, that I live up to their*

confidence. What I do reflects on them, and they are held accountable for my actions and behavior."

"Exercising the right to criticize my family, school, or government includes the responsibility to suggest how practical improvements can be made."

"To promote better communication in the family. I will practice courtesy and consideration for others. I will let my parents know I care about them. They are affected by pressures and problems of everyday living just as I am. I will try to cheer them up when they need a lift".

SOME EXTRA TIPS TO PARENTS

In addition to improving communication, there are actions parents can take to help their adolescent through the teenage years. The old saw, "actions speak louder than words," is particularly appropriate where parental influence on children is concerned.

1. **Try to set a good example.** Children learn by what they see. Too often people say one thing and do another. "Do as I say and not as I do", will not carry much weight. Eventually children will ask such questions as "What's wrong with smoking pot when my parents get stoned on alcohol?"

2. **Supervise and guide.** Although teenagers are capable of handling certain privileges and responsibilities, they still need help in setting limits on their freedom and behavior. Deciding with the teenager what they limits and policies are usually elicits more reasonable attitudes. Moderate and selective guidance is one of the best ways to prevent a breakdown of communication.

3. **Communicate,** in words and actions, what you expect of your children. Although teenagers may appreciate a share in some decisionmaking, they do not want parents to give up authority or to be wishy-washy. Parents who appear confused about firmness and discipline, who are inconsistent, or who disagree between themselves can be perceived as weak and divided. Teenagers need the security of knowing where their parent stand and what parents expect of them.

4. **Respect the adolescent's desire for individuality and independence.** Parents do, and should, attempt to influence their children, but this is quite different from trying to force them into preconceived molds to fit parent's desires. Parents can accept and respect their teenagers as individuals without accepting all their ideas. The reverse is also true; teen s can maintain respect for parents while rejecting some of their beliefs. One expert in family problems suggests that parents assume the role of watchful bystanders, ready to come forward when help is needed.

5. **Take an interest in your children's activities and friends.** This helps to reduce the distance between the generations, since it demonstrates your acceptance of their world. Give the youngsters time to be with their friends and make their friends welcome when they come to visit. Taking an interest in your children's activities and friends does not mean taking on the role of friend or invading your child's privacy. Teenagers need separateness and privacy just as parents do.

6. **Try not to overreact.** Many parents brace themselves for the onslaught of adolescence, convinced that it is bound to be a long, hard struggle. Consequently, they are quick to overreact the first time their teenager steps out of line. They punish severely, withdraw trust, and lose

confidence in the youngster, thus severing the lines of communication. It is only natural for adolescents to test their parents' authority while trying to assert themselves. At the same time, they are trying out their own competence. Parents must let their children make mistakes-and at the same time be ready to help when help is needed.

It is not realistic to expect complete harmony between the generations. Nor is it pleasant to live through a period of bickering and strain, no matter how temporary. When both parents and teenagers make efforts to communicate and respect each other, adolescence can be an exciting period of discovery for all concerned.

(from a publication of the National Institute of Mental Health, Div. of Scientific and Public Information, Public Health Service, 5600 Fishers Lane, Rockville, MD 20857.

Appendix G

DOs - DON'Ts and Adolescent Suicide Profile

DOs - DON'Ts List

When intervening in a suicide crisis...

Do...

- Trust your suspicions that the person may be self-destructive.
- Clear other students from the scene.
- Communicate your concern for the well-being of the person.
- Try to sound calm and understanding.
- Mention the person's family as a source of strength, but if he or she rejects the notion, back off quickly.
- Assure the student that he or she has done the right thing by talking to you. Try to win the student's trust. Assure the student that emergency help is coming. Tell the student that there are options available.
- Get the student to talk. Listen!! Listen!! Listen!! Repeat what you hear the student saying Help the student define the problem. Acknowledge the student's feelings ("You sound really angry." "You must feel humiliated.")
- Explain the temporary nature of the person's problems. Explain that the crisis will pass in time, and therefore suicide would be a permanent resolution of temporary problem.
- Get professional help. Encourage the individual to seek help from a school counselor, minister or someone who can help solve the problems. If the person resists, get help for them.

Do Not...

- Allow yourself to be sworn to secrecy by the suicidal person. You may lose the confidence of the person, but you may save a life.
- Leave the person alone if you believe the risk for suicide is immediate.
- Act shocked at what the person tells you.
- Stress the shock and embarrassment that the suicide would be to the person's family before you are certain that is not exactly what he or she hopes to accomplish.
- Debate whether suicide is right or wrong. Such an argument may do more harm than good by making the person feel more guilty.
- Minimize the threat. Take all threats seriously.
- Be concerned about long periods of silence. Give the student time to think.
- Lose patience with the student.
- Promise confidentiality. Instead promise help and promise privacy. A suicidal incident should not be discussed in the teacher's lounge or with other students.

Adolescent Suicide Profile

- 84 percent have a step parent.
- 72 percent have at least one parent absent.
- 20 percent who complete suicide are alcoholics.
- 70 percent are first born.
- 16 percent have an alcoholic parent.
- 22 percent have suicidal mothers.
- 42 percent have witnessed physical abuse between family members.
- 30 percent have school problems.
- 52 percent of events leading to an attempt are related to marital problems of parents.
- Suicidal adolescents have a high percentage of tragic deaths among their close relatives.
- Suicidal adolescents are more likely to be above grade level academically.

SOURCE: *Focus on Teen Suicide: Governor's Office for Children*, Vol. 1, No. 3 (December 1988)

Appendix H

Dealing with the Suicidal Youngster

Dealing with the Suicidal Youngster

Anger is sometimes directed inwardly and manifests itself as suicidal behavior. Dr. Calvin Frederick of the National Institute of Mental Health offers the following preventive steps for the mature adult to take in dealing with the suicidal youngster.

Step 1: **Listen.**
The first thing a person in a mental crisis needs is someone who will listen and really hear what is being said. Every effort should be made to understand the feelings behind the youngster's words.

Step 2: **Evaluate the Seriousness of the Youngster's Thoughts and Feelings.**
If the person had gone far enough to make specific, self-destructive plans, the problem is apt to be more acute than when the thinking is less definite.

Step 3: **Evaluate the Intensity or Severity of the Emotional Disturbance.**
It is possible that the youngster may be extremely upset but not be suicidal. If a person has been depressed and then becomes agitated and moves about restlessly, this is usually cause for alarm.

Step 4: **Take Every Complaint and Feeling the Person Expresses Seriously.**
Do not dismiss or undervalue what the youngster is saying. In some instances, he or she may express the difficulty in a low key, but beneath the seeming calm there may be profoundly distressed feelings. All suicidal talk should be taken seriously.

Step 5: **Do Not Be Afraid to Ask Directly If the Individual Has Entertained Thoughts of Suicide.**
Suicide may be suggested by the youngster but not openly mentioned in the crisis period. At an appropriate time, experience shows that harm is rarely done by inquiring directly into such thoughts. As a matter of fact, the individual frequently welcomes the query and is glad to have the opportunity to open up and bring it out.

Step 6: **Do Not Be Misled By the Youngster's Comments That He Or She Is Past the Emotional Crisis.**
Often the youth will feel initial relief after talking of suicide, but the same thinking will recur later. Follow-up is crucial to ensure a good treatment effort.

Step 7: **Be Affirmative But Supportive.**
Strong, stable guideposts are essential in the life of a distressed individual. Promote the youngster's emotional strength by giving the firm impression that you know what you are doing and that everything possible will be done to prevent the young person from taking his or her life.

Step 8: **Evaluate the Resources Available.**
The individual may have both inner psychological resources, including various mechanisms for rationalization and intellectualization which can be strengthened and supported, and outer resources in the environment such as a minister, relatives, and friends whom one can contact. If these are not available, the problem is more difficult. Continuing observation and support are vital.

Step 9: **Act Specifically.**
Do something tangible; that is, give the youngster something definite to hang onto, such as arranging to see him or

her later or to contact another person. Nothing is more frustrating to the person than to feel as though he or she has received nothing from the meeting.

Step 10: **Do not Avoid Asking For Assistance and Consultation.**
Call upon whomever is needed, depending upon the severity of the case. Do not try to handle everything alone. Convey an attitude of firmness and composure to the person so that he or she will feel something realistic and appropriate is being done to help.

Additional preventive techniques for dealing with persons in a suicidal crisis:

- Arrange for a receptive person to stay with the youth during the acute crisis.
- Do not regard the youngster with disbelief or reject his or her thinking.
- Make the environment as safe as possible.
- Never challenge the individual in an attempt to shock him or her out of his or her ideas.
- Do not try to win arguments about suicide. They cannot be won.
- Offer and supply emotional support for reasons for living.
- Give reassurance that depressed feelings are temporary and will pass.
- Mention that if the choice to die is carried out, the decision can never be reversed.

"These procedures can help restore feelings of personal worth and dignity, which are equally as important to a young person as to an adult," says Dr. Frederick. In so doing, he adds, the adult helping person can make the difference between life and death, and a future, potentially productive young citizen will survive.

Source: Care Unit Hospital of St. Louis.

Appendix I

Some Resources

Some Resources

Print:

Counseling the Adolescent
Individual, Family and School Interventions
Edited by Jon Carlson and Judith Lewis
Governor's State University, IL

A new book of intervention strategies emphasizing methods proven to work, its content is organized into the three major areas of individual (e.g., suicide, teen pregnancy, violent behavior), family (the changing family, the restructured family) and school (excellence, motivation, counseling, minority issues).

Love Publishing
1777 South Bellaire St,.Denver, CO 80222
(303) 757-2579 9-8831/paper/ISBN 0-89108-204-2 $19.95

On Base! The Step-by-Step Self-Esteem Program for Children from Birth to 18
Edited by Barb Friedman and Cheri Brooks

Developed and field tested by 36 leading authorities in childcare, BASE (Behavioral Alternatives through Self-Esteem) is a series of exercises and communications that encourage positive behavioral strengths.

Built on the concept that positive interactions create positive concepts, BASE is a group of activities to do and share with a child. The activities are short, simple and positive. The activities and communications were developed for children in 15 levels from birth to 18.

Child Welfare League of America
C/O C55C
P.O. Box 7816
300 Raritan Center Parkway
Edison, NJ 08818-7816
1987, 1990/214pp/paper/0-933-701-43-8/#4352 $14.95

Youth Suicide: A Comprehensive Manual for Prevention and Intervention
Written by Barbara Barrett Hicks and Edited by Larry Barber

Detecting the warning signs and responding appropriately can mean the difference between life and death. *Youth Suicide* gives information to develop an effective approach to prevention, intervention and postvention, including...

- the eight most common characteristics of youth at-risk of committing suicide
- a training program with sample curricula for staff and volunteers
- seven guidelines for classroom presentation
- essential legal issues and four steps to preventing malpractice suits.
- ways to spot a potential problem and five steps for effective intervention
- four essential components for an effective prevention program and means of evaluating their efficacy in the absence of an actual crisis
- nine crucial steps to take when a suicide occurs

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P.O. Box 7816
300 Raritan Center Parkway
Edison, NJ 07818-7816
1989/131pp/paper/#4379 $19.95

Youth Suicide: What the Educator Should Know
Eleanor C. Guetzloe

Much has been done in the public media to heighten awareness of the signs of impending suicide attempts. This book is written especially for educators. It tells what the school can do, including the components of an effective prevention program. Guetzloe urges schools to consider the special education model in developing appropriate interventions for special-needs students.

The book will help teachers, principals and counselors become more alert to the danger signs and adolescent crises that may trigger suicide. It will help educators assess suicide potential and suggest appropriate communication procedures.

The Council for Exceptional Children
1920 Association Drive, Dept. C590
Reston, VA 22091-1589 (703) 620-3660
1989/208pp/ISBN 0-86586-188-9. CEC/ERIC $18.50/Members $14.80

Adolescent Suicide: Some Clues to Understanding and Prevention

This eight-page pamphlet provides an overview of the problem. Additional readings are suggested. Limited quantities are available without charge from The Communication & Public Service Division, Father Flanagan's Boy's Town, NE 68010.

Suicide in Young People

This basic overview of the youth suicide problem is one of a series of inexpensive booklets on related issues.

Life Skills Education
541 Columbian St.
Weymouth, MA 02190

Suicide in Youth and What You Can Do About It

Two versions of this small pamphlet are available, one subtitled "A Guide for Students," and the other, "A Guide for School Personnel." Many similar inexpensive materials also may be ordered from the same publisher, including curriculum guides and resource lists.

Youth Suicide National Center
1811 Trousdale Dr.
Burlingame, CA 94010

Teen Suicide: What You Can Do

This basic brochure stressing the need for the involvement of education in prevention is appropriate for use with teachers, students or parents. It can be custom-printed with up to 10 lines of local crisis intervention or hotline telephone numbers or with names of school personnel when larger quantities are ordered.
Kidsrights, 3700 Progress Blvd., Mt. Dora, FL 32757

Videos:

Available through...

Human Relations Media
175 Tompkins Ave.
Pleasantville, NY 10570
1-(800)-431-2050

Suicide Prevention: A Teacher's Training Program

This comprehensive program looks at the underlying social and psychological causes of teenage suicide and examines the roles of teachers and other school personnel in the early identification of suicidal behavior in students. It offers a broad overview of the developmental factors involved in teen suicide and should help teachers recognize and respond appropriately to suicidal threats and gestures among students.
G-806-CS...Two-part Filmstrip - $115 or G-806-VS (1/2" VHS)...Filmstrip on Videocassette - $139.

My Friend Wants to Die: Understanding Teenage Suicide

Why are today's teens committing suicide in record numbers? What are the underlying psychological and social factors contributing to this problem? How can you tell when a friend is considering suicide, and what can you do to prevent it? These and other questions are addressed in this two-part program.
G-807-CS...Two-part Filmstrip - $115 or G-807-VS (1/2" VHS)...Filmstrip on Videocassette - $139.

*Managing Stress, Anxiety and Frustration**
Consultant: Melvyn Hollander, Ph.D., Director, Center for Behavioral Psychotherapy

A filmstrip that defines stress, analyzes its causes and effects and provides viewers with specific techniques for managing the stress that compromises their health and well-being. Techniques offered include biofeedback, meditation, progressive relaxation and guided imagery.
G-725-CS...Four-part Filmstrip - $189 or G0725-VS (1/2" VHS)...Filmstrip on Videocassette - $199.

* *Award-Winner: International Audiovisual Competition, Society for Technical Communication, Outstanding Academic Non-Print Materials, Choice Magazine*

*Suicide: Causes and Prevention**

Dramatic, but not sensational, the film probes the social and psychological causes of one of the major killers of young adults, dispels misconceptions and forcefully argues that most suicides can be prevented. It encourages your students to watch for symptoms in themselves and others and teaches students appropriate techniques for intervention in a potential suicide.
G-604-CS...Two-part Classic Filmstrip - $98 or G-604-VS (1/2" VHS)...Filmstrip on Videocassette - $111.

* *Award-Winner: National Council on Family Relations*

Sudden Adolescent Death: How to Prevent It

Using case histories to challenge students, this program teaches young people their crucial roles in reducing the extent of teenage death through suicide, reckless driving, drug abuse and violence. It teaches students to recognize danger signs in emotional patterns and prepares them to help others while minimizing unacceptable risks to themselves.
G-783-CS...Two-part Filmstrip - $115 or G-783-VS (1/2" VHS)...Filmstrip on Videocassette - $139.

(**Videos,** *continued*)

The Eight Stages of Human Life: Prenatal to Late Childhood*

The program describes the first four stages of the human life cycle: prenatal, infancy, early childhood and late childhood. It also explains physical, mental and emotional development as well as the transitional crises and problems specific to each stage. The theories of Freud, Erikson, Piaget, Gould, Sheehy and Kohlberg are discussed, then illustrated in the daily lives of growing human beings.
G-708-CS...Four-part Classic Filmstrip - $151 or G-708-VS (1/2" VHS)...Filmstrip on Videocassette - $159.

* *Award-Winner: National Council on Family Relations*

The Eight Stages of Human Life: Adolescence to Old Age*

The program leads students through the last four stages of human life, emphasizing the adolescent's search for identity, the adult's quest for stability, the middle-ager's midlife crisis and the older person's physical decline and life review.
G-709-CS...Four-part Classic Filmstrip - $151 or G-709-VS (1/2" VHS)...Filmstrip on Videocassette - $159.

* *Award-Winner: National Council on Family Relations*

Andrea: A Friend in Need (1987)

This film is intended for use in small-group training sessions conducted b a trained group leader. It is designed for one 15-minute uninterrupted viewing followed by a second viewing with discussion at designated intervals. The focus is on the friends and family of a young suicide victim. A leader's guide is included.
Barr Films, 12801 Schabarum Ave., Irwindale, CA 91706-7878

But Jack Was A Good Driver (1974)

Though this film is not as new as some others, it is an excellent look at "autocides" and other cases that are reported as accidents but may be suicide. Actor Beau Bridges narrates. The instructor's guide, prepared by Eleanor D. Macklin, is a valuable resource in itself, providing background, discussion questions and references. CRM McGraw Hill Films, 674 Via de la Valle, Del Mar, CA 92014

It Did Happen Here: Coping With Suicide (1987)

A 30-minute film (available as a videocassette or as a set of two filmstrips and two audiocassettes) that provides information on coping with the aftermath of suicide. Interviews with friends of suicide victims illustrate the difficulties faced in such situations. A multifront approach (school, home, community) is stressed. Guidance Associates, Communications Park, Box 3000, Mount Kisco, NY 10549-0900

Agencies and Organizations:

Arizona

Sources of help are readily available in many communities for troubled teens and their families. Check the yellow pages for the numbers of suicide hot-lines, suicide and crisis centers and community mental health centers. During business hours, the American Association of Suicidology (303-692-0986) will provide a referral to the closest suicide crisis center in your area.

Metropolitan Phoenix

- *Teens Talk to Teens*: 249-2915
- *Foundation Against Suicidal Teens* (FAST): 242-9979, 1-800-338-6014
- *Tumbleweed*: 271-9849
- *Valley Youth Organization Crisis Center*: 269-6899
- *South Mountain Crisis Line*: 257-9345
- *Suicide Stressline*: 271-0695
- *Teen Lifeline*: 271-0695, 248-TEEN
- *Phoenix Crisis Intervention*: 258-8011, Ext. 247
- *Terros Crisis Line*: 249-1749
- *West Valley Camelback Hospital Free Crisis Assistance*: 588-4700
- *Crisis Intervention/Scottsdale Police*: 946-6511
- *Tri-County Community Behavioral Health Center*: 835-3655
- *Jewish Family Children's Services*: 257-1904
- *Chicanos Por La Causa*: 258-3641

Statewide Services

Flagstaff:	Coconino Guidance Center 774-3351
Kingman:	Kingman Aid to Abused People 753-4242
Lake Havasu:	Havasu Crisis Line 855-8877
Safford:	Safford Crisis Line 428-5711
Tucson:	Tucson Help on Call 323-9373 Our Town 323-1706
Yuma:	Casa de Yuma 342-DONT

National

The following national organizations can supply information on suicide prevention. (Please send stamped, self-addressed business envelopes with your requests.)

American Academy of Child Psychiatry,
3615 Wisconsin Ave. N.W., Washington, DC 20016.

American Association of Suicidology, 2459 South Ash, Denver, CO 80222.

American Psychiatric Association, 1400 K Street N.W., Washington, DC 20005

Link Counseling Center, 218 Hilderbrand Ave. N.E., Atlanta, GA 30328

National Association of Social Workers, 7981 Eastern Ave., Silver Springs, MD 20910

National Committee for Youth Suicide Prevention,
230 Park Ave., suite 835, New York, NY 10169

National Mental Health Association, 1021 Prince St., Arlington, VA 22314

National Peer Counseling Association
Unit of Educational Development, Bradley University, Peoria, IL 61625

National Institute of Mental Health
Suicide Research Unit, Room 101C26, 5600 Fishers Lane, Rockville, MD 20857

School Suicide Prevention Materials

The following groups have developed suicide prevention materials for schools and will provide publication lists upon request. Educators should also check with local suicide prevention centers and community mental health centers for ideas and program guides.

American Association of Suicidology, 2459 S. Ash, Denver, CO 80222

Bergen Regional Counseling Center, 395 Main St., Hackensack, NJ 07601

Appendix J

Example of Crisis Management Training

Crisis Management Team Training

After reading the scenario, please take a few minutes to jot down your thoughts about the special implications of responding to this situation and answer the following questions:

What are the special implications for students, parents, faculty or community?

How would you use the Crisis Management Team (identify level of response)?

Make a schedule for the day (include logistics):

What other resources would you need outside of the Crisis Management Team?

What kind of follow-up would you arrange and when?

GOALS:
Develop a core of individuals who respond assertively and sensitively to crises experience the emotional impact of responding to a crisis develop a crisis manual detailing different levels of response identify training and prevention needs

TEAM SELECTION:
Broad representation of school community
Engage all levels and perspectives
Time and energy commitment

Part One

Goal: Experience a crisis and recognize groups' ability to manage that crisis

Step 1: Simulated crisis to be responded to within strict time frame respond to four basic questions:

- What groups will be in need of support, information, and direction?
- What are the goals?
- Who will be responsible for what?
- How will they carry out these tasks?

Step 2: Process the feelings

- How did you feel when you first heard?
- How did your feelings change as you worked with your group?
- What process did you use for answering the questions?

Step 3: Making the task manageable

Divide into four groups:

- Organizational
- Staff
- Students
- Parents

Develop a goal statement and list of questions

Part Two

Goal: Manage the task by creating structure and strategies

Small groups meet independently to develop:

- An outline of who, what, when, where, why, and how
- A list of resources and materials
- Identify additional training needs

Part Three

Goal: Refine the materials, plan and promote crisis manual

Step 1: Each group demonstrates response to a simulated crisis

Step 2: Large group critiques each presentation

Step 3: Small groups meet to refine the information:

What can you implement right now?

What else do you need to do?

Who will organize the information?

Identify training and prevention needs

Step 4: Discuss methods for educating the school community about the crisis management team, how to access it, and when to use it.

ORGANIZATION

Who is responsible for what?
What level of response is needed?
How will other school personnel be contacted?
How will parents be notified?
What community agencies/individuals will be brought in?
- How will they be identified?
- How will they find their way around campus?

Will the daily class schedule be changed?
What is the schedule of events for the day
What legal/ethical issues need to be addressed?
What rooms will be set aside for:
counseling, information center, groups?
Who will handle the media? How?
What arrangements are there for a memorial service?
What other schools/services need to be contacted?

STAFF

What steps are being taken to include all school personnel
(teachers, custodians, secretaries, security, food service, bus drivers)
What are the details of the event? Updates?
How will this information be shared with the staff?
What resources are available for distressed teachers?
(team members in the class? substitutes? counseling?)
What is expected from staff?
What is the schedule of events for the day? follow-up?
What direction/agenda should they follow in the classroom?
What information do they have/need about pertinent issues?
(child's view of death, why people choose suicide, etc.)
How will they identify and refer high risk students?

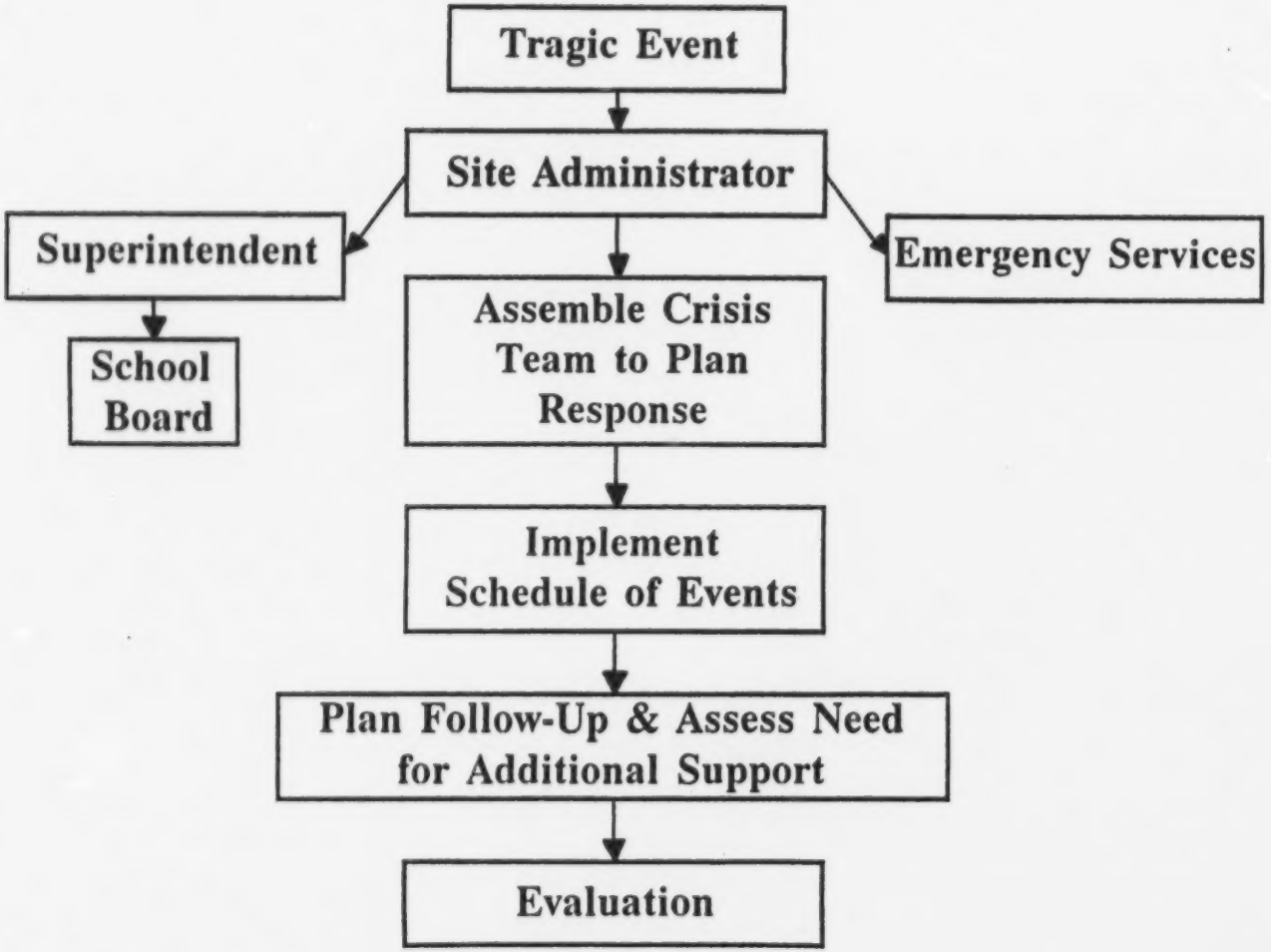
STUDENTS

What information will be given to students?
How will students be informed?
Who will tell them?
What will be the best setting to allow students an opportunity to express their grief?
What are some strategies to help facilitate this process?
How will at-risk students be identified and referred?
What resources are available in/out of school for needy students?
What steps are being taken to teach:
-peer support
-coping skills
-on-going recognition of the grieving process
What resources are available following the crisis?
What attention will be paid to siblings and friends in the same or other schools?

PARENTS

How will the parent meeting be structured?
What school/community representatives will be present?
What opportunity will parents be given to speak directly with school personnel?
What information will parents be given? have?
What information will be helpful to parents to help their children?
(at-risk behavior, modeling grief, community resources)
How can parents help the school?
How will parents be notified about additional information?

Crisis Management Team Response



Intervention Strategies

- PROVIDE SAFETY AND SECURITY
- IDENTIFY AND ACKNOWLEDGE FEELINGS
- ALLOW VENTILATION AND DISCUSSION
- CONVEY ACCURATE AND COMPLETE INFORMATION
- PREDICT POSSIBLE AND POTENTIAL REACTIONS
- IDENTIFY COPING SKILLS AND SUPPORT NETWORKS
- DEVISE PLAN OF ACTION OR RESPONSE
- ARRANGE REFERRALS AND FOLLOW-UP

Crisis Management Team Training

Worksheet #1a

Groups, Sub-Groups and Special Implications

Target group CHILDREN

List all sub-groups:

Special Implecations for Working with them:

Crisis Management Team Training

Worksheet #2

Response plan including schedule of events

Target Group_____

What needs to happen right now?

What needs to happen tonight?

What is the schedule of events for tomorrow?

What kind of follow-up will be arranged?

Components of Crisis Response Plan

1. **Pre-Planning**
2. **Flow Chart & Designation of Responsibilities**
3. **Choosing Team Members**
4. **Training**
5. **Creation of a Resource Manual**
6. **Coordinate with Emergency Service Agencies**
7. **In-Service School Community**
8. **Evaluation**
9. **Identify Prevention Implications**
10. **Care for the Caregivers**

What's Left TO DO?

CHECK LIST OF TASKS & RESPONSIBILITIES

TYPES OF CRISIS & LEVEL OF RESPONSE

PACKAGE AND UPDATE CRISIS RESPONSE MANUAL:

- Classroom activities
- Bibliographies
  (books, articles, & brochures)
- Resource lists
  (school, district, & community)
- Sample fact sheets, letters, & agendas
- Sample memorials/eulogies
- Interactions with emergency service agencies

IN-SERVICE SCHOOL COMMUNITY

IDENTIFY PREVENTION NEEDS

PRACTICE SESSIONS FOR THE TEAM